The view from the front line: family-centred care 'from conception to reception' in Lambeth.

Abstract body

Lambeth Early Action Partnership (LEAP) is a 10 year Big Lottery Funded programme, which aims to improve outcomes for children from conception to their fourth birthday. LEAP aims to support the social, emotional, communication and language development of babies and children, improve their diet and nutrition, as well as help support parents' wellbeing, their social networks and the strength of their communities and wider environment. LEAP also aims to facilitate systems change so resources are focused on prevention, with parents and the community as key drivers of local services,so that pregnant women and children are supported by a strong, family-centred single pathway, around which organisations work together and information flows freely.

An innovative 'LEAP Health Team' was created, comprised of representatives from primary care practitioners who look after women and babies: a health visitor (HV), a general practitioner (GP), and one midwife (MW) from each of the two local hospital trusts, facilitated by a public health specialist. Seconded from their front-line jobs one day a week (April 2017-April 2019), their remit was to investigate how specialities could work together better to improve services for pregnant women, parents and young children. The LEAP Health Team took an inductive approach to understanding how each speciality provides care. Methods included shadowing, keeping reflective notes and exploring communication and referral pathways and attending cross speciality educational events. We met with a range of stakeholders across all the different specialities to better understand the issues around early years care for children and their families, and build engagement. Our plan was to clarify existing pathways between the professionals and train clinicians to use existing pathways more effectively. We also wanted to identify potential improvements to care pathways for future improved working.

Range of professionals involved in initial stages of information gathering

GP and Primary care nurse engagement

GP surgery visits
Educational talks given at GP locum group, practice nurse forum, safeguarding children forum, CCG led educational event.

Midwife engagement

Frontline midwives (including using a survey monkey)
Midwifery managers
Hospital safeguarding midwives
Community midwives matron and administration team
Breastfeeding teams

Health Visitor Engagement
Health visitors
Health visitor managers and commissioners (joint MW/HV management meetings)

Family engagement
LEAP parent champions
Father's study workshop
Breastfeeding workshop

Management and commissioners
GP commissioners Lambeth CCG
Hospital Trust managers at each trust

IT professionals
Chief Data officer NHS England
IT local care record leads
IT maternity leads in both hospitals
Child health Information system (CHIS) representative

Public Health
Public health consultants

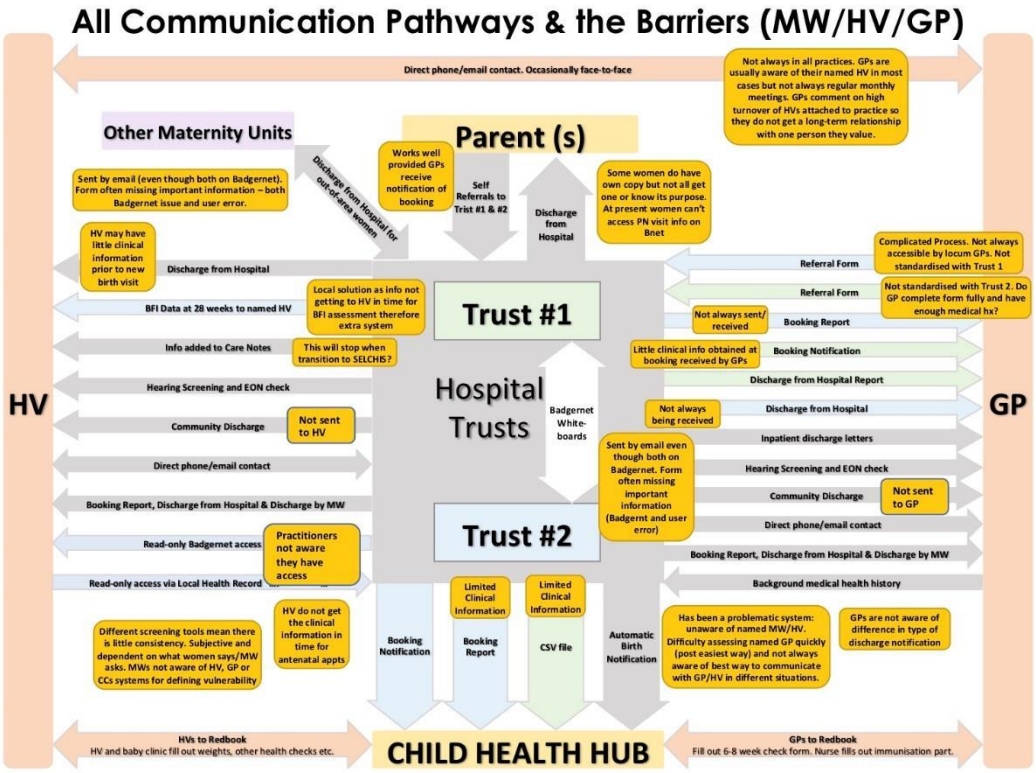
Council
Early years services commissioners
Children centre commissioners
Local children centre managers
Local council housing officers

Community paediatrics
Consultant Community paediatrician
Consultant hospital paediatrician

National discussion group
Better Start big lottery conference

A pictorial map of what did and did not work on the ground locally was co-produced. All forms of communication between MWs, HVs, GPs, women and hospital trusts were represented in a map form, and the barriers to this communication were superimposed on top,to give a visual idea of the

complexity of the communication system. -see image 1.Three key areas emerged as barriers to providing safe care for women and babies: inter-professional communication, assessment and referral issues, and duplication of work.



Inter professional Communication

We found that there were significant areas where HVs, MWs and GPs were not aware of each other's practice or information needs. All three use different IT systems that are not integrated. Plans for linking systems were either not yet available or not yet in use. We felt this limited information sharing could have safety implications, and also means women have to repeat the same information constantly to different health professionals. For example, previously GPs did not know if a HV had visited a child or family unless they contacted the HV directly by e-mail, telephone or spoke face-to-face. GPs already had IT access to a read only version of the HV's computer notes via the same IT system (the 'Local Care Record') which they use to access hospital patient's notes in South London, but very few GPs were aware they had this access.

17 GP practices were visited individually by the LEAP GP and public health specialist between September 2017 – Jan 2018 and shown on their practice computers how to gain access to view the

HV notes. In addition, presentations were given at a Lambeth wide GP educational event on children's services, at a GP locum group and practice nurse forum and information was also sent in a GP electronic newsletter to all Lambeth GPs. GPs can now see the notes a HV has made regarding a home visit or a referral, so co-ordination of care has improved and time can be saved by not having to phone or write e-mails to HVs. GPs can also gain valuable further information about home situation and vulnerability factors from the HV notes that might not be recorded on the GP computer system and reduce duplicate referrals by both GPs and HVs.

Similarly midwives were previously not always aware of a pregnant women's past medical history if they self referred for pregnancy care. If a GP referral was received it did not always contain enough medical information. The LEAP GP was aware that hospital clinicians could access the IT notes of GPs through the shared Local Care Record IT platform, so it seemed logical that midwives should too. However, local midwives did not have access to this system. The LEAP midwives had meetings with IT lead midwives, and one hospital has now given all midwives access to the to Local Care Record system so enabling them to see GP and HV notes and important information in the past e.g. mental health problems, that patients may not always disclose, so vulnerability factors for a family can be fully assessed now. Work is underway to enable midwives from the second hospital to follow this lead – as the Health Team has no power to implement change directly, they must collaborate closely with colleagues at all levels to encourage and support such change.

IT collaboration has also changed communication between MW and HV. Previously HVs received a list of women who were due to give birth, but no clinical information was included, so HV relied on individual referrals from MW, which were hampered by difficulties faced by MW in identifying the correct HV. Consequently HV had to just assume all these ladies would be ' universal care' i.e. low risk when actually this was not the case. As a result of meetings by one Health Team MW, the HVs in the local area have now been given read-only access to the MWs IT system, so they can look at the notes of women who are pregnant and make an assessment of vulnerability from the clinical information recorded antenatal by the midwives. This means any extra support needed can be given before baby is born, rather than waiting until the HV uncovers all the issues at the new birth check. This also fulfils the Public Health England's requirements within the Healthy Child programme government document.

Women are asked for their consent for information to be shared between their healthcare providers at booking, and safeguards are in place in that if women ask for particular information to be kept confidential, this is recorded separately and not uploaded to the Local Care Record, or to read-only versions of local IT systems.

Assessment and referral issues

The LEAP Health Team discovered that often problems related to communication and referral between GPs, HVs and MWs were due to professionals not being aware of existing referral pathways or not using existing communication tools effectively. In order to address this, the LEAP MW in one Trust developed training session called 'Communication and Referral' for the midwives' annual 'Mandatory Training'. This focused on 'back to basics' reminders about using existing tools (i.e. how to fill in the Red Book to ensure appropriate handover to HV; the importance of posting the 'GP Summary' of bookings to GPs etc. and awareness about existing referral pathways for vulnerable women. The session also raised awareness that midwives had recently been granted access to GP and HV notes via a shared IT platform. Although MWs had all been sent an email about this exciting development, few midwives had understood it's potential. These sessions have been well received,

and repeated with different cohorts of midwives. The positive feedback is enabling a move towards implementing a similar training session at the other maternity unit.

During the process of shadowing each other's practice, one of the issues that concerned the Health Team was that GPs, MWs and HVs all had different approaches to assessing vulnerability in families. GPs, in common with Social Services and Children's Centres, used the 'Four Tier' system (with Tier 1 being suitable for universal primary care interventions, and Tier 4 requiring specialist safeguarding/mental health intervention). HVs used three categories ('Universal', 'Universal Plus' and 'Universal Plus Partnership') but understood how the Four-Tier system mapped onto this. We

felt the referral and assessment pathways for serious mental illness and safeguarding worked well, but lower level vulnerability in pregnancy and perinatal period was not always detected. If vulnerability was detected, professionals were not always clear where to direct families to get support.

MWs ask pregnant women about a wide variety of issues at booking and throughout their pregnancy, but have no formal tool for assessing vulnerability. In addition, few midwives are aware of the GP or HV systems. This lack of a shared language limits midwives' ability to make appropriate referrals, and their ability to assess their caseload in terms of vulnerability, which has resource implications. The Health Team felt that extending the use of the Four-Tier system into maternity would be beneficial for all those caring for pregnant women.

The Health Team midwives identified that a 'Level 1-4' categorisation question was already available on their electronic patient record system, although it was not currently being used. Meetings were held with safeguarding midwife teams and consultant midwives, and the use of a four-level system developed by the LEAP Health Team has now been agreed, designed to be used by anybody who provides maternity care (MW, HV, GP, obstetricians, neonatologists etc.). The tool is based in part on traditional safeguarding tiers, but takes a more holistic approach, incorporating the mother and family's wellbeing as well as that of the child. The new maternity assessment tool is now in the early stages of being approved by both trusts and local commissioners, before being presented for approval and implementation within the Local Maternity System (LMS), after which plans will be made for implementation across southeast London. The support the Health Team has received for this initiative from senior managers from both local maternity services, suggests that the Health Team have identified an important gap in the service.The Health Team has also shown flexibility in understanding when a potential intervention requires consensus and implementation beyond the LEAP area, and in fact beyond the local council area as well. We hope that early intervention and early help can form part of families care pathway between services,to reduce escalation of support needs as their vulnerability has been identified at an earlier stage.

Focusing on women and families' needs

As well as asking professionals' opinions, the LEAP health care team also looked at a piece of research commissioned by LEAP, interviewing local women and aimed at understanding their interaction with local services ('My Maternity Journey: Pregnancy and the Early Years, LEAP. 2018). One of the main conclusions was that Children's Centres were valued and highly regarded as places to go to socialise with other mothers and to get help and support. However, many GPs and midwives are unaware of the services these centres offer, where they are, or how families can access them. Health visitors however have closer links and often see families in these centres. The LEAP GP contacted each the local children centre managers from the children centre closest to each GP practice in the target area, and went on a joint visit with them to the practice, along with the LEAP

public health specialist. This meant that the children centre managers themselves could discuss the services they offer and foster communication directly with the GP practices, Since then, children centre managers have been e-mailing up to date timetables of activities in children centres to local GP practice managers so these can be publicised. Each GP practice was also given contact details for their local children's centre, address, telephone numbers and e-mail, as well as contact details for their health visiting team and other local children services to keep as a reference.

The Health Team midwives have also begun to collate a similar easy-reference list for midwives that will work across both local Trusts and the two local authorities they serve. Although it seems like a basic need, local midwives currently only know women's GP's postal address: they do not have the

GP email or direct phone line, or information about their local HV or Children's Centre. It has taken a significant amount of work by the Health Team (and LEAP admin staff) to pull together a database with this information. Once disseminated, this list is expected to save MWs' time and to facilitate appropriate referrals.

Most of the mothers interviewed by the researcher had attended antenatal classes, and valued them as groups for socialising and making supportive friends. Several mothers felt health visitors could make a contribution. At present health visitors do offer antenatal classes, but they have poor attendance at these classes and they cover similar information to midwives classes. The LEAP health team is currently working on including HV in the well-attended MW-led antenatal classes.

Most parents felt the sharing of information between GPs, MWs and HVs was positive, provided it was for the good of the health and well being of both mother and child, and non-judgemental. Some expressed surprise that information is not already shared. Only two out of the sixteen women interviewed thought information sharing was currently "good", and over one third were not sure if it currently happens. Parents also mentioned repetitive questions from each health care professional as being frustrating. This confirmed our impressions as clinicians that communication and information sharing is a clear priority,and will be a focus of our work in the future.

Our work in the Health Team has enabled us to address long-term frustrations within our individual practice. By coming together as one team we have been able to use our expert knowledge and skills of our own specialties to analyse the finer detail of multiple care pathways families find themselves on when they become pregnant and have young children.Our analysis of the finer details has provided useful information for those involved in service design and delivery, and enabled us to engage stakeholders and commissioners in investigating innovative ways to work more cohesively but also, more importantly, within the current financial and government changes, to use current systems more efficiently and to ultimately benefit those in our care who need it most.

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Abstract extra text

The LEAP health team initially spent time shadowing each of their colleagues in each of the three professional areas –midwifery, health visiting and general practice. We then met with a range of

professionals and families to understand what the system is like now, areas that work well and areas that could work better. The professionals involved in these meetings were cross boundaries –i.e. secondary care and primary care together, across professional job boundaries i.e. midwives and GPs, and practice nurses, and also across health and council service boundaries –children centre managers and commissioners from the council, GPs, public health specialists. This cross boundary working is a key recommendation from the Better Births Maternity Review.

The team has a very collaborative and supportive feeling, with all members having equal value within the team, and we all shared the joint vision that we could improve communication, quality and hopefully outcomes of care for children and families within our local health care system.Having paid, protected time away from our usual duties to address local issues, which is a rare luxury for most frontline clinicians, meant that we could devote the time needed to affect change, rather than having an idea but not having the time or resources to push this through, whilst trying to juggle clinical caseloads at the same time. We also all appreciated the lack of micromanagement or set targets in this project. Although slightly daunting initially, as there was only a very broad aim, after a few weeks of shadowing each other and speaking to key professionals and families it became clear that we should map the processes and barriers to communication that existed between our professions and service users, and this process clarified practical ways we could begin to improve how we work together.

We respected individuality, difference and diversity within and between the professions by involving a wide number of them in initial meetings to discuss clinical care, what works well and what could be improved. Sometimes this involved a midwife speaking to other professionals in the midwifery profession but sometimes this was cross professional e.g. MWs speaking to GPs and vice versa. The two hospitals were represented, so different structures and ways of doing things could be compared and best practice established.

As all clinicians within the team work in the same geographical area and are experienced clinicians, we bring years of experience and knowledge about local needs to the team. The area is one of significant socio-economic and ethnic diversity and one member of the team provides antenatal education in the primary second language locally, so has first-hand experience of their needs and challenges. The equity and accessibility of local services is a central concern of the Health Team

There is a strong sense of teamwork within the LEAP health care team and increased respect for each other's professions. Bias and suspicion between professions are not uncommon, and our experience of being in the Health Team has shown to what extent meeting face to face helps foster respect and better working relationships. We have shown that by having a representative from each speciality within the team, we can help solve issues that are occurring between specialities. This is because each professional can use their knowledge of local systems, practice and hierarchy to effect change.

Individual and team morale and motivation has been high. We divided our work into quick wins, medium term goals and longer-term objectives, which are more complex and will take more highlevel work and time. This meant we were rewarded with some quick successes even after a few months, so we felt motivated to take on some of the more complex issues. The LEAP Health Team was originally conceived of as a six-month initiative but the effectiveness of the team, which to a great extent is due to its cohesion, resulted in the team's remit being extended to two years.

We identified that there was little integration of training for different clinicians, either as students or professionals, despite great overlaps in the scope of their work. GPs and HVs have joint child

protection training locally, but not much else. Through the LEAP Health Team we have shared details of what training opportunities there are in our speciality areas. One Health Team MW has spoken at several GP educational events and one practice nurse educational event. Similarly the LEAP GP has presented at a MW educational event. We hope to extend this to HV and make them regular events. This sharing of training means we have much more awareness and understanding of our colleagues' roles.

Our work has given us the impetus to promote the benefits of multidisciplinary working and how to overcome potential barriers. We will be taking this further with a borough-wide inter-disciplinary health and social campaign to highlight the impact of Adverse Childhood Experiences (ACEs) for families, the importance in prevention and improving outcome through resilience and how interprofessional relationships is what will change culture between disciplines to ultimately change the experiences of families in our care.

The value of having front-line practitioners feeding into service design, highlighting areas where systems assumed to be working are not practical 'on the ground' cannot be underestimated. We discovered that some midwives and GPs were aware of a particular specialist service but were unclear about their acceptance thresholds or how to refer to them. The LEAP Team contacted the service to find out the best referral pathway, and in one case were signposted to a passwordprotected referral form, that was required because the team used a non-nhs.net email account. The LEAP health Team felt that the use of a password presented an additional barrier to referrals, so suggested that the service changed to an nhs.net email address to make this process easier (confidential information can be emailed using nhs.net due to end-to-end encryption). Although there was initial resistance to this suggestion, when asked how many referrals they had actually received from midwives and GPs the specialist team decided that perhaps it would be worthwhile exploring this possibility to facilitate more referrals.

As front-line practitioners ourselves, we understand how difficult it is to change practice. The handson training for GPs and MWs on accessing new IT systems, which was delivered by the Health Team, has proved invaluable in making tools such as this go 'live'. While managers may put systems in place to improve practice, practitioners on the shop floor may not always understand the process or purpose of new initiatives, and implementation plans must always include checking if new methods are being used. On reflection there is no point in developing a change if no one is aware of it – publicity and training are as important as the change itself. Practical issues are also very important i.e. which button to press on which screen, and showing people in person had much more impact than information sent via e-mail. Using informal opportunities to show colleagues 'which button to press' during their everyday clinical work was as important as formal educational training.

Senior engagement from all disciplines early in the process helps to build relationships. We have learnt that it is the relationships between individuals and services which will ultimately change practice. Spending time building these relationships and overcoming barriers together strengthens everyone's will to succeed and bring those skills and knowledge into our individual organisations.

Anticipated further collaborative working

We would like to expand inter-professional joint training by developing a platform for MW, HV and GPs to learn together so there is more understanding of each other's roles and aspects of communication. Initial plans are to develop shadowing sessions for newly qualifies MW, HV and GP trainees in their final year, improving inter-disciplinary understanding and respect.

We would also like to continue working with the council to integrate and promote health and council services. This work has started with the promotion of children centre services by health care staff but will also continue in forums such as 'Better Start board' containing both health and council staff to improve early years services and though joint council and health commissioning boards for child and maternity care.

The LEAP GP is also co-ordinating a project which will be starting in the next few months, to proactively identify children at risk of poor outcomes, so help can be offered to these families. These identified children would then be discussed at a regular GP and HV meeting to agree an appropriate course of action. We are also looking at whether as a second stage MW can attend some of these meetings to discuss vulnerable families antenatally.

As well as continuing our work on communication and referral, we would like to explore duplication of work areas and if this can be made more efficient, reducing the burden on over-extended clinicians. Two areas identified is overlap between the HV and GP's 6-8 weeks check on baby and mother at a time when parents have a lot of appointments, and between the 10-day MW discharge visit and the initial HV assessment at day 10-14 postnatally. The Health Team is exploring how these visits might be spaced out differently, integrated or at least improve handover and information sharing, so that visits complement each other and families to have more seamless care.

Overall, women and their families should notice that their care should be more joined up and holistic with an individualised tailored plan to meet their needs and those of their children and wider family.